RESPONSE: ADDICTION, MEMORY, AND SPIRIT

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Vitka Eisen: The article reinforced some conversations I've had recently with colleagues. We were reflecting on people we've known who had a good 4 or 5 years of recovery under their belt and then relapsed. What appeared to connect these relapses were folks returning to places that were triggering for them.

John Wanner: We see this all the time. Right now, we've got 74 patients, and at least eight of them relapsed after between 5 and 15 years of sobriety. The article does a good job of making it clear why this happens. I'm going to send it to my colleagues. If we can explain this to patients, they will give more credence to the recommendations we make in treatment.

Eisen: I was left thinking about the challenges related to today's shorter stays in treatment. When Walden House was a therapeutic community, people stayed in the program for 2 years. Now a typical stay is 6 months, with a couple months in outpatient aftercare. That gives us a lot less time to help patients rewire their brain, form new associations, change associations that formerly triggered drug use, learn some stress management skills, and titrate their exposure to the stresses outside the program. Many of our folks need to start new lives from scratch because of the communities they came from and because their friends and family members are all drug-involved.

Wanner: Some of the addiction literature today is pointing in the direction of longer stays. I think that Alcoholics Anonymous recognized that, without knowing the science, many years ago when they came up with the idea of 90 AA meetings in 90 days. What we try to do at Father Martin's Ashley is to give our patients some coping skills while they are in residence and then move them on to some additional treatment, whether it's outpatient, extended care, halfway house, or whatever, because they still need to be in an environment that's recovery-based.

Stages and models

Wanner: We see patients in both of the stages of addiction Dr. Gould describes. Sometimes patients who are still in the earlier stages look at those in the later stages and say, "What am I doing here? I don't belong here. I'm not that bad." We try to tell them that even though they are not yet using every day, not waking up with the shakes, neither were these other people when they were at your stage. We also are more likely to prescribe an anti-craving medication for patients in the second stage.

Eisen: Walden House clients typically are indigent with lengthy histories of substance abuse, often co-occurring disorders, and often histories of incarceration. Most are in the second stage of addiction where they no longer get any pleasure from drugs. However, we used to have a residential treatment program for court-referred adolescents, most of whom were first-stage users. They tended to have lengthy histories, for such young people, of complex trauma, and many serious difficulties in their lives. Drugs often were the best thing they had going on, so it was a different challenge to try to get them to replace drugs.

Interestingly enough, some of our court-referred clients are drug dealers who are first-stage recreational drug users. With them, we try to look at drug abuse together with other behaviors, particularly criminal behaviors, that are thrill-seeking and seem to produce very similar types of rewards in the brain.

Wanner: Dr. Gould's definition of addiction as "a disorder of cognition" and "a disease of pathological learning" is a neurobiologist's view. From a treatment and patient education perspective, Father Martin's Ashley uses the broader biopsychosocial model of the disease, which also focuses on the social, environmental, and genetic factors that influence the neurobiological processes.

Eisen: We assess many things when a patient arrives in our program, but we don't make any formal assessment of cognitive status. That might be useful if we had all the time and resources in the world, but for now, it's more useful to try to understand how our clients learn and what their life challenges are. We can use that information to identify the interventions that will be most effective for them. If we subsequently see that a client has some cognitive impairment, we can recalibrate our expectations of him or her or rework a treatment plan.

We assume that everybody comes in learning in different ways and at different paces. There are auditory learners and people who learn by talking a lot in group. There are those who need to have things written down and others for whom writing is very anxiety-producing. You can alienate clients if you don't understand how they learn best and what they think is the most effective way for them.

Wanner: The neurobiological information is useful for putting to rest the idea that individuals become addicted because they are weak-willed. I use it in a lecture to families, and many of them thank me afterwards and say that they now understand why their family member makes bad decisions about drugs.

Eisen: Given the nature of addiction, we

have to strike a very delicate balance with our clients. We say: "You have a brain condition." But, at the same time, we say: "You have choices and the ability to change." The balance between personal responsibility and acknowledgment of a health condition is challenging, and it's tricky to strike it appropriately. We want our clients to recognize that they are faced with challenges that are real, embedded in the brain. But we don't want them to think: "It's not my responsibility."

Memory and spirit

Wanner: Many of our patients have memory problems. Many of our older patients are fighting not only years of drug and alcohol abuse, but also the normal decline in memory that happens with aging. Some of the problems are drug-specific. For example, lately we're seeing patients come in much more cognitively impaired from marijuana, due to the increasing potency of that drug over the past 5 or 6 years.

Eisen: Some patients are aware that they have cognitive problems. They'll say, "I don't remember the way I used to be able to," things like that. Or they may say, "What have these drugs done to my mind?" Some attribute their thinking problems to drugs, and some don't make that connection.

Wanner: Patients don't remember where they're supposed to be, what they heard at a lecture, or what assignment they're supposed to do. In those cases we try to have them write things down. If somebody's having serious memory issues, we'll try to hook them up with a buddy or ask the group members to help them. These problems do improve during treatment.

Eisen: We also post lots of visual cues—staff names and charts of who does what, schedules, sayings, and slogans that help reinforce the treatment environment. Memory typically may start to improve, maybe, 3, 4, or 5 months into treatment. At that point patients are starting to feel better, more capable. They're creating relationships with friends and preparing or already in a job search. There's a general cognitive improvement that occurs as part of a complicated interaction among drug use, withdrawal, abstinence, and mood. Many of our patients have co-occurring mood disorders, and depression of course has an impact on cognition.

Wanner: This is an area that could use some research. Some of the rehabilitation of patients with brain injuries already uses computer simulations, but to my knowledge, there's not been much work applying that approach in the addictions field. Cognition-enhancing medications also seem to hold promise.

Spiritual practices can actually start to re-regulate some of the neural dysfunction that takes place as a result of addiction. We're not talking about religion, per se, but encouraging clients to live as good people and get more connected to their lives in a positive way. In some manner, this spiritual work, which can include prayer or meditation, starts to re-regulate defective neural circuits and compensate for some of the cognitive deficits that addiction causes. Spiritual experiences can eventually replace some of the powerful negative memories associated with the drugs and give people a reason to stay abstinent.

Eisen: I think that we aim for the same end, which is creating other kinds of reinforcing experiences for clients so that they can practice sentient abstinence, if you will. Our focus is really on creating positive relationships among the clients as a group and with family members (if they are able to participate), staff, ex-residents, church groups, and 12-step programs. We focus on maintaining healthy relationships that are positively reinforcing for clients.

Wanner: Much of what you just said about positive relationships actually falls in the purview of what we would consider spiritual experiences.

Early exposure

Eisen: Dr. Gould's section on prenatal exposure to drug and alcohol abuse is especially interesting. I'm not sure that the field has recognized how many of the people we see as adult clients were prenatally exposed to drugs and alcohol. We have to learn how to work with what may be some pretty significant deficits, impairments, or learning challenges. Historically, we thought about the social environment of being raised in a family with addiction but less about the organic impact of being prenatally exposed.

Wanner: I've probably worked with at least three or four father and son pairs over the years, and we have also had grandparents, parents, and children come through here. I can't really say that we see cumulative increases in cognitive deficits from one generation to the next, as Dr. Gould's text might lead you to expect. We don't measure for that, per se. However, the addicts who come in today, especially the young ones, are different from those of 10 years ago. There is a much greater variety of drugs available, and we are seeing more cross-addictions.

Eisen: The clients we see today have a much higher level of acuity than 25 years ago, in terms of severity of addiction and the amount of co-occurring disorders. We speculate on the reasons. Prenatal exposures might be one, and the cumulative impact of multiple generations of addiction and alcoholism, as well as the policy of incarcerating drug abusers, may be others.